Interoperability:
Provider EHR and ASIIS Electronic Data Exchange
Initial Interest Form

Please complete pages 1 and 2 of this form (to the best of your ability) to indicate your interest in participation with the ADHS interoperability project. Fax as directed below.

A. Provider Organization

Organization Name:				
ASIIS IRMS Id:				
Street Address:				
City:				
State:				
Zip code:				
Phone/Fax:	Phone ( )		Fax ( )	
Number of Providers	# of MDs:	#of DOs:	# of NPs:	# of PAs:
Patient Descriptors	# of Children:	# of Adults:	% of Patients on AHCCCS:	

B. Electronic Health Record System (EHR)

EHR Name:	
EHR Vendor:	
Software version:	
Years in use:	

C. Data Exchange

What version of HL7 do you plan to interface ASIIS with (ask your vendor)?

_____ HL7 2.3.1

_____ HL7 2.5.1

Preferred Transport Mechanism (ask your vendor)

_____ Web Service

_____ HTTPS POST

_____ ASIIS Bridge

_____ Other, please specify _____

D. Office Contact

Primary Office Contact

Name:	
Email:	
Phone number:	( )

Primary Technical Contact

Name:	
Email:	
Phone number:	( )

Secondary Technical Contact

Name:	
Email:	
Phone number:	( )

Other Contacts

Possible Project Team Roles	Personnel Name	Telephone Number	Email
IT Support			
Primary Decision Maker			
Project Manager			
Business Operations			